
Female to Male Breast Reconstruction

The great challenge in reconstructing a male- appearing chest from a female breast is the management of the overlying breast skin. There is always a "skin excess" when the underlying glandular and fatty breast tissue is surgically removed. One goal in gender reassignment surgery is to manage this skin excess with a minimal amount of scarring. Excess skin can easily be cut away but every incision in surgery leaves a scar — the challenge for the surgeon is to remove this excess skin and to "hide" the incisions in natural folds, previous scars, or in the pigmented skin of the nipple-areolar complex.

The most critical factor in determining the appropriate procedure for each patient is the breast size. A very large breast (C-cup or larger) always requires a more extensive incision or series of incisions. Obviously, the larger the breast size, the more overlying skin there will be left to manage after the underlying breast tissue is removed. My preference for the large breast is to place an incision in a horizontal direction with a gentle curve that follows the curve and lower border of the pectoralis muscle. This scar, although it is long, can heal very nicely and can be "hidden" in the fold that is created by the well-developed pectoralis muscle. With a long incision, there is no problem removing the skin that is in excess after the breast tissue is removed and this procedure can be performed in one stage with only a small percentage of patients requiring any surgical revisions. Chest hair growth is also very beneficial in helping to conceal the scarring. With this procedure, I often will completely remove the nipple areolar complex, decrease it to the appropriate size, and replace the nipples in their new elevated and more lateral position as skin grafts. Liposuction also is an integral part of any breast reconstruction surgery to help create a smooth contour and transition from the breast to the surrounding chest wall.

The B-cup breast size has always created controversy for the plastic surgeon. A patient could be evaluated by 10 different surgeons and receive 10 different opinions on how the procedure should be performed and where the incisions should be placed. Common incisions used are: 1) the inverted "T", 2) a horizontal incision on either side of the nipple, 3) a vertical incision under the nipple which curves outward near the fold of the pre-existing breast, and 4) the peri-areolar incision.

My preferred incision for the B-cup breast and smaller is the periareolar incision. The average male nipple-areolar complex (NAC) size is about the size of a dime or slightly larger. The average female NAC size is about the size of a half dollar, but it will be much larger in larger breasts. An incision is always made around the entire border of the NAC to reduce the size. This incision is called a periareolar incision. Because this incision is placed at the junction where the normal skin joins the pigmented or colored skin of the NAC, this incision can "hide" nicely and can appear to be the border of the pigmented skin. The excess skin is removed in a circular fashion around the NAC. The challenge is then to close the large skin circle to the dime-sized new NAC. The discrepancy in size of the outer skin circle to the inner circle (NAC) creates a very pleated skin closure — much like a drawstring purse. With normal healing, all skin will contract and tighten. We are relying on the skin contraction properties (which are different in

each patient) to tighten the skin and to reduce the appearance of the pleating. Almost every patient will require a minor surgical revision to manage persistent pleating after the first stage procedure. If bothersome pleating exists after the revision, then the patient and surgeon must decide on creating another scar and in which direction. Often this additional scar or scars will be short and well-accepted by the patient because residual pleating rarely extends for more than an inch from the border of the NAC. Obviously, if the scar can be limited to the periareolar incision, this is the most desirable situation as there would be no obvious scarring that the patient might have to "explain" to someone when the chest was exposed.

In summary, the goals of female to male breast reconstruction surgery are to remove the glandular and fatty breast tissue with a smooth transition to the surrounding chest wall, to decrease the NAC size, and to perform the surgery with acceptable and minimal scarring.

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